Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Aetna Better Health of KS
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453
PA Medical Phone 855-221-5656
PA Medical Fax 855-225-4102

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-943-6474

Asthma Agents PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

CHECK ONE: ☐ **Drug dispensed from a pharmacy (pharmacy benefit)**
☐ **Drug administered in an office or outpatient setting (medical benefit)**

MEMBER INFORMATION		
Name:	Medicaid ID:	
Date of Birth:	Gender:	
PRESCRIBER INFORMATION		
Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp
- KS HCPCS lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:
1. Complete **the Member/Prescriber Information** portion above and **Section I** for **ALL** requests.
2. Complete **Section II** if this request is also for a Non-Preferred PDL drug.
3. **Complete Section III for all clinical information required.**
4. Complete the section above and **Section IV only,** if the requested medication is a renewal.
5. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Select the appropriate medication(s) for this request:
☐ Benralizumab (Faserna®)
☐ Dupilumab (Dupixet ®)
☐ Mepolizumab (Nucala®)
☐ Omalizumab (Xolair®)
☐ Reslizumab (Cinqair®)

NDC/HCPCS (J Code)	Strength	Dosage Form	Quantity	Directions for Use

Indication/Diagnosis:

Is the requested medication being prescribed for an FDA-approved indication? ☐ YES ☐ NO
Indication: _____
ICD-10: _____
Patient's weight: _____ ☐ lbs. ☐ kg

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long it is retained. In no event are you permitted to use or re-disclose such PHI.

PATIENT NAME:		MEDICAID ID:	

SECTION II: NON-PREFERRED MEDICATION

1. Is the medication requested a non-preferred medication on the Kansas Medicaid preferred drug list (PDL)?
   KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf

   ☐ YES ☐ NO – Proceed to Section III

   If YES: Does the patient have a documented clinical rationale for using a non-preferred medication that is supported by the product labeling as specified in the Non-preferred PDL PA criteria?
   Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf

   ☐ YES ☐ NO

   Please submit documentation of clinical rationale to support the use of the requested non-preferred medication.

   _____

SECTION III: CLINICAL INFORMATION

1. Is this a new or renewal request for this medication?
   ☐ New ☐ Renewal – Proceed to Section III.
2. Please document the prescribing physician's specialty.
   ☐ Pulmonologist ☐ Allergist ☐ Immunologist ☐ Other

   A. If other, has the prescribing provider consulted with one of the provider specialties listed above in question 2?
      ☐ YES – If YES, please document the provider's name, specialty and date of consult:

      Provider name: _____ Specialty: _____ Date of Consult: _____

      ☐ NO

3. Please list all medications the patient is taking or has previously tried and failed for treatment of this diagnosis.

*Specify medication name, Action Taken (continue medication, discontinue medication due to inadequate response, contraindication, intolerance) and dates of previous medication trial.

Medication name	Action Taken	Dates of trial

4. Please list all medications the patient will use in combination with the medication requested for the treatment of this diagnosis.
   Medication name(s): _____

5. Does the prescriber attest that the patient is not currently on another biologic or janus kinase (JAK) inhibitor?
   ☐ YES ☐ NO

6. Please provide the baseline FEV_1 value (include units if applicable) _____

7. Please provide the following information:	Value (Include Units if Applicable)
• For all agents, number of exacerbations within the last 12 months (with dates) Exacerbation is defined as requiring the use of one of the following: o Oral/Systemic Corticosteroids o Urgent Care or Hospital Admission o Intubation	

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PATIENT NAME:		MEDICAID ID:	

SECTION III: CLINICAL INFORMATION (continued)	
• For Omalizumab, please provide one of the following: o Perennial aeroallergen skin test result o In vitro reactivity to a perennial aeroallergen	
• For Dupilumab, please provide one of the following: o Oral Corticosteroid dose for corticosteroid-dependent Asthma o Blood eosinophil count	
• For Benralizumab, Mepolizumab, and Reslizumab, please provide the following: o Blood eosinophil count	

SECTION IV: RENEWAL

1. Does the prescriber attest that the patient has received clinical benefit from continuous treatment with the requested medication?
   ☐ YES ☐ NO
2. Please provide one of the following:
   - o Most recent FEV_1 Value (Include Units if Applicable): _____ Date: _____
   - o Effect on Exacerbations in the past 12 months (with dates)
     Describe changes in exacerbation(s) compared to baseline:

     _____

     _____

     _____

     _____
3. Please provide the patient's current dose: _____
4. Does the prescriber attest that the patient is not currently on another biologic or Janus kinase (JAK) inhibitor?
   ☐ YES ☐ NO

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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